DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CO	NSTRUCTION 01	(X3) DATE : COMPL	
ANDILAN	OI CORRECTION	155322	A. BUILD	ING	01	08/24/2	
		100022	B. WING	CTDEET A	DDRESS, CITY, STATE, ZIP CODE	00/2 1/2	
NAME OF P	ROVIDER OR SUPPLIER				CR 800 E 92		
RENAISS	SANCE VILLAGE				VAYNE, IN46814		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<del>                                     </del>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification	K00	000			
	· ·	sure Survey was					
		he Indiana State					
	Department of						
	accordance with 42 CFR 483.70(a).  Survey Date: 08/24/11						
	Facility Number: 000215						
	Provider Number: 155322						
	AIM Number: 1	00267600					
	Companya Manaya	Vallage Life Cafety					
		Kelley, Life Safety					
	Code Specialist						
	At this Life Safe	ety Code survey,					
		llage was found in					
		with Requirements					
	for Participation	·					
	Medicare/Medi						
	Subpart 483.70						
		he 2000 edition of					
	the National Fir						
		PA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.	capaneres and 110					
	This one story	facility was					
	<u>-</u>	be of Type V (111)					
	construction ar						
		,					
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  01	(X3) DATE S COMPL 08/24/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	alarm system we detection in the open to the corresident rooms. The facility has and had a cens of this survey.  Quality Review by Code Specialist-Me  The facility was compliance with aforementioned.	e corridors, areas ridor and all on the 300 hall. a capacity of 96 us of 90 at the time  Robert Booher, Life Safety dical Surveyor on 08/31/11.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED					
		155322	1			08/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/2 //2	
NAME OF PRO	OVIDER OR SUPPLIER				CR 800 E 92		
RENAISSA	ANCE VILLAGE				VAYNE, IN46814		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
SS=E	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  Based on observinterview, the factor and automatically closed and automatically closed and of the residuing room.  Findings include Based on observinterview, the residuining room.  Findings include Based on observinterview automatically closed and automatically	em option is used, the areas of other spaces by smoke and doors. Doors are in-rated or field-applied at do not exceed 48 inches the door are permitted.  Vation and acility failed to ingle fire doors chen, a hazardous ged to lose and latch. ractice could affect lents in the main  e:  Vation with the inpervisor on 40 p.m., the fire the three ink failed to latch. This was by the Maintenance	K	0029	CORRECTIVE ACTION FOR AFFECTED RESIDENTS The closer and the top hinge on the kitchen door were adjusted allowing for proper latching. IDENTIFICATION/CORRECT ACTION FOR POTENTIALL AFFECTED RESIDENTS All facility doors were inspected proper latching. MEASURES FOR PREVENTION All facility doors are checked monthly for proper operation. QA FOR PREVENTION A monthly log kept by maintenance employ designee and any future issue will be presented by the Environmental Manager at the monthly QA&A meeting for discussion and recommende plans of action. EFFECTIVE DATE The effective date is September 6, 2011.	for S.	09/06/2011

000215

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322			(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION  01	(X3) DATE : COMPL 08/24/2	ETED
	PROVIDER OR SUPPLIER		-	6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 WAYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0038 SS=E	readily accessible with section 7.1.  Based on obser interview, the french fersure the mean through 6 of 6 accessible for reclinical diagnost specialized sector LSC 19.2.2.4 within a requires shall not be equor lock that requires tool or key from Exception No. It locking arranged delayed egress in health care of portions of head occupancies, where the sector is after the respecialized sector is after the respecialized sector in the	acility failed to ans of egress exits was readily esidents without a sis requiring urity measures. requires doors ed means of egress uipped with a latch quires the use of a an the egress side. I requires door ements without shall be permitted occupancies, or alth care here the clinical sidents require urity measures for ovided staff can such doors at all ficient practice or residents and e:	K	0038	CORRECTIVE ACTION FOR AFFECTED RESIDENTS The exit code (mmyy) to disengathe magnetic lock on all 6 exit doors is posted at each door IDENTIFICATION/CORRECTED RESIDENTS The exit code (mmyy) to disengathe magnetic lock on all 6 exit doors is posted at each door MEASURES FOR PREVEN All 6 exit doors are checked monthly for continued postinithe code. QA FOR PREVENTION A monthly preventative maintenance lokept by maintenance employ designee and any future issuiff be presented by the Environmental Manager at the monthly QA&A meeting for discussion and recommended plans of action if required. EFFECTIVE DATE The effect date is September 6, 2011.	ge ge it TIVE Y ee ge it TION g of g is ree or res ne	09/06/2011

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Event ID:

J81S21

Facility ID:

000215

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	01	(X3) DATE SURVEY  COMPLETED				
111,12121111	or confidence.	155322	A. BUILDING		08/24/2011			
			B. WING	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIER		6050 S CR 800 E 92					
	SANCE VILLAGE		I	WAYNE, IN46814				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE			
		11:30 a.m. to 3:00			J.M.D			
	p.m., all exit do							
	•	cked and could be						
	-	ring a code, but						
	· ·	ot posted. Based						
	on interview with the Director of							
	Nursing at 2:30	p.m., not all						
	residents have	a clinical diagnosis						
to be in a secure building. She								
stated residents without the								
	clinical diagnosis requiring							
specialized security measures did		urity measures did						
	not have access	s to the code.						
	3.1-19(b)							
K0056		natic sprinkler system, it is						
SS=E		ance with NFPA 13,						
		stallation of Sprinkler e complete coverage for all						
	portions of the buil	ding. The system is						
		d in accordance with NFPA						
		le Inspection, Testing, and ater-Based Fire Protection						
		supervised. There is a						
	•	water supply for the						
	system. Required equipped with wat	sprinkler systems are						
		e electrically connected to						
	the building fire ala	arm system. 19.3.5						
	Based on obser		K0056	CORRECTIVE ACTION FOR AFFECTED RESIDENTS				
	interview, the f	•		identified unsupported armo				
	=	nkler system was		the sprinkler pipe was modif	ed by			
		ordance with the		an outside vendor to comply	with			
	requirements o	f NFPA 13,		proper code.				

000215

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION 01	COMPL		
ANDILAN	or connection	155322		ILDING	01	08/24/2	
		100022	B. WIN		DDDDGG GYMY GM:	00/24/2	V 1 1
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
RENAIS	SANCE VILLAGE				CR 800 E 92 VAYNE, IN46814		
				<u> </u>			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ne Installation of	<u> </u>		IDENTIFICATION/CORREC	CTIVE	DINE
		ms, 1999 edition.			ACTION FOR POTENTIAL		
		on 6-1.1.5 states			AFFECTED RESIDENTS T		
	•				building was inspected for p	-	
		g or hangers shall			sprinkler head armover sup No other issues noted.	port.	
		support nonsystem			MEASURES FOR PREVEN	<u>ITION</u>	
		Section 6-2.3.4			The building is monitored		
		ulative horizontal			annually for proper armover		
	_	nsupported armover			support. QA FOR PREVEN This building is monitored	<u>ITION</u>	
	to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches				annually for proper armover		
					support. An annual log is ke		
					maintenance employee or		
		e. These deficient			designee and any future iss will be presented by the	ues	
	-	I affect any resident			Environmental Manager at t	he	
	on the 200 hal	I and at the nurses'			next scheduled quarterly QA		
	station.				meeting for discussion and		
					recommended plan of action		
	Findings includ	de:			required. <u>EFFECTIVE DAT</u> effective date is September		
					2011.	Ο,	
	Based on obse	rvation with the					
	Maintenance Si	upervisor on					
	08/24/11 at 2:	:10 p.m., there was					
	an unsupporte	d armover of the					
		measuring twenty					
		n length above the					
		r the 200 hall fire					
	_	as acknowledged by					
		ce Supervisor at the					
	time of observa	•					
	3.1-19(b)						

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	PROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 WAYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
K0062 SS=F	continuously main condition and are periodically. 19. 25, 9.7.5  Based on recordinterview, the fidocument and tests for 1 of 1 25, Table 5–1.1 through 5–3.2. following week pump house conditions with piping free of lepressure gauge and suction results Additionally, a pump test shall weekly. This deaffects all occurrents.	acility failed to conduct weekly fire pumps. NFPA and then 5-2 4.4 requires the ly inspections: the onditions such as 40 degrees F, sing louvers are free pump system valves fully open, eaks, suction line reading is normal, ervoir is full. no flow ten minute be performed eficient practice pants.	K	0062	CORRECTIVE ACTION FOR AFFECTED RESIDENTS A weekly, no flow, ten minute test is conducted by mainter personnel.  IDENTIFICATION/CORRECT ACTION FOR POTENTIALL AFFECTED RESIDENTS A weekly, no flow, ten minute test is conducted by mainter personnel. MEASURES FOR PREVENTION A weekly operational fire pump test lo the pump test is maintained maintenance personnel. GEOR PREVENTION A week of the fire pump test is kept maintenance employee or designee and any future issue will be presented by the Environmental Manager to the administrator immediately at the monthly QA&A meeting discussion and recommender plan of action if required. EFFECTIVE DATE The effect date is September 9, 2011.	pump nance  TIVE Y  pump nance PR  g for by A ly log by ues he nd at for ed	09/09/2011

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Event ID:

J81S21

Facility ID:

000215

If continuation sheet

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<b>l</b> i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  O1 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155322	A. BUII	LDING	01	08/24/2	
		199922	B. WIN			00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RENAISS	SANCE VILLAGE		6050 S CR 800 E 92 FORT WAYNE, IN46814				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	DEFICIENC!)		DATE
	Maintenance Su	•					
		review, he was not					
	aware of this re	equirement.					
	3.1-19(b)						
K0067 SS=F	comply with the pri are installed in acc manufacturer's spe NFPA 90A, 19.5.2	ecifications. 19.5.2.1, 9.2, 2.2					
	Based on record observation and facility failed to undetermined rin the ceiling version and provided maintenance at years in accord 90A. LSC 9.2.1 conditioning, his ductwork and rishall be in accord 90A, Standard for Air-Condition Ventilating Systems 1999 Edition, 3 requires at least fusible links shis dampers shall be verify they fully provided, shall	d review, d interview; the ensure an number of dampers ents were inspected ecessary least every four ance with NFPA requires air eating, ventilating elated equipment ordance with NFPA for the Installation ning and tems. NFPA 90A, 4.4.7, Maintenance, ot every 4 years, all be removed; all	KO	0067	CORRECTIVE ACTION FOR AFFECTED RESIDENTS  Maintenance is performed ever 4 years on all fire dampers, including fusible link removal verification of damper functionality and closure, late inspection, and lubrication of moving parts.  IDENTIFICATION/CORRECTED RESIDENTS  Maintenance is performed ever 4 years on all fire dampers, including fusible link removal verification of damper functionality and closure, late inspection, and lubrication of moving parts.  IMEASURES IN PREVENTION A log docume fire damper maintenance every years will be maintained by maintenance personnel.  IMEASURES IN PREVENTION A log documenting fire damper maintenance every 4 years is kept by maintenance personnel and any future issues will be	very  th  TIVE Y very  th  th  th  th  A	09/09/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	LTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155322	A. BUILD	DING	<u>01</u>	08/24/2	
		133322	B. WING			00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RENAISS	SANCE VILLAGE		6050 S CR 800 E 92 FORT WAYNE, IN46814				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	l	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		ntol .	DATE
	as necessary.				presented by the Environmer Manager or designee to the	itai	
	practice affects all occupants.				administrator immediately an	d at	
	Findings include:				the next scheduled monthly QA&A meeting for discussion an recommended plan of action if	and if	
	Based on interv	riew with the			required. <u>EFFECTIVE DATE</u> effective date is September 2		
	Maintenance Supervisor on 08/24/11 at 11:20 a.m. when				2011.	,	
	asked if there v	vere fire dampers in					
	the ventilation system, he stated						
	there were but he was unable to						
	provide an exac	ct number. When					
	asked for docu	mentation of an					
	inspection, he	stated there was no					
	•	available. Based					
	on observation						
	Maintenance Su						
		01 p.m., there was					
		e 300 hall fire wall.					
	a damper at the	2 300 Hall life Wall.					
	3.1-19(b)						
K0070 SS=E	in all health care o non-sleeping staff the heating elemen	ating devices are prohibited ccupancies, except in and employee areas where nts of such devices do not es F. (100 degrees C)					
	Based on obser	vation, interview	K00	)70	CORRECTIVE ACTION FOR	_	09/09/2011
	and record review; the facility				<u>AFFECTED RESIDENTS</u> The heating element of the identif		
failed to enforce the pol		e the policy for the			activity room fireplace was	ieu	
	use of 1 of 1 po	ortable space			disconnected to eliminate any	y	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION  01	(X3) DATE S COMPL 08/24/2	ETED	
RENAISS	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)			ΓE	(X5) COMPLETION DATE
	could affect and activity room.  Findings include Based on an ob-Maintenance St. 08/24/11 at 12 was an electric residents' active an interview will Supervisor at the observation, the does blow heat room. Based of with the Mainterview of the servation of the ser	servation with the upervisor on 2:55 p.m., there fire place in the ity room. Based on the Maintenance he time of e electric fire place ed air into the n record review enance Supervisor t 11:30 a.m., the t allow space			possibility of heat emanating the fireplace.  IDENTIFICATION/CORRECY ACTION FOR POTENTIALLY AFFECTED RESIDENTS The heating element of the identificativity room fireplace was disconnected to eliminate an possibility of heat emanating the fireplace.  MEASURES FOR PREVENTION The identified fireplace is inspected annual safety issues. Any portable, decorative fireplaces purchasin the future, will also have the heating element disconnecter resident safety.  PREVENTION An annual preventative log is kept by maintenance personnel and future issues will be presented the Environmental Manager designee to the administrator immediately and at the next scheduled monthly QA&A meeting for discussion and recommended plan of action required.  EFFECTIVE DATE effective date is September 9 2011.	TIVE Y e fied  y from FOR ly for sed ne d for any ed by or r  if The	
K0147 SS=D	Code. 9.1.2 Based on obser interview, the f	vation and acility failed to exible cords such cord were not	K0	147	CORRECTIVE ACTION FOR AFFECTED RESIDENTS The identified extension cord in the MDS office was removed and replaced with a compliant postrip. The identified extension cord in the 300 hall furnace residents.	e ne d wer n	09/09/2011

li ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155322	B. WIN			08/24/2	U11
NAME OF I	PROVIDER OR SUPPLIEF	₹	-		ADDRESS, CITY, STATE, ZIP CODE	-	
DENAIO	041051/11405			1	CR 800 E 92		
RENAIS	SANCE VILLAGE			FORT WAYNE, IN46814			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
IAU		LSC IDENTIFYING INFORMATION)	-	IAG	was replaced with a receptac		DATE
	wiring. LSC 9.	•			for the modem.	SIC	
		g and equipment to			IDENTIFICATION/CORREC	TIVE_	
	1	FPA 70, National			ACTION FOR POTENTIALL	_	
		, 1999 Edition.			AFFECTED RESIDENTS Th		
		le 400-8 requires,			identified extension cord in the MDS office was removed and		
	unless specific	• •			replace with a compliant pow		
		and cables shall not			strip. The identified extension	n	
		ubstitute for fixed			cord in the 300 hall furnace r		
	wiring of a structure. This deficient practice was not in a				was replaced with a receptace for the modem. MEASURES		
					FOR PREVENTION The buil	_	
	resident care area but could affect				continues to be monitored		
	any number of	staff.			quarterly for improper use of		
					extension cords. <u>QA FOR</u> <u>PREVENTION</u> A log is kept		
	Findings includ	de:			quarterly by maintenance		
					personnel and any future iss	ues	
	Based on obse	rvations with the			will be presented by the		
	Maintenance S	upervisor on		Environmental Manager or	ο <b>Λ</b>		
	08/24/11 betv	veen 12:20 p.m.			designee at the monthly QA& meeting for discussion and	XA	
	and 12:30 p.m	., a heavy weight			recommended plan of action	if	
	extension cord	was plugged in			required. EFFECTIVE DATE		
		power to a power			effective date is September 9	9,	
		S office and a heavy			2011.		
	weight extensi	<del>-</del>					
	1	er for a modem in					
	1	rnace room. These					
	were acknowle						
		upervisor at the					
	time of observ	•					
	diffe of observe	ations.					
	3.1-19(b)						
	J.1-19(D)						